# NC Managed Care Capitation Rates – Care Management Assumptions

Updated August 31, 2023

## Introduction

The purpose of this document is to provide additional information about the assumptions underlying the care management component of capitation payments to NC Medicaid Managed Care Standard Plan Prepaid Health Plans (Standard Plans). The Standard Plan capitation rates developed by the North Carolina Department of Health and Human Services (the Department) reflect its belief that investment in robust community-based care management will drive improvements in care outcomes and achieve greater value from the state's Medicaid dollar. **This document provides assumptions for the Standard Plan managed care capitation rates for State Fiscal Year 2024 (July 1, 2023-June 30, 2024).** Rate updates will be considered as part of capitation rate setting for future state fiscal years. The rates in this document do not include any changes to rates related to Medicaid expansion.

Under the Advanced Medical Home (AMH) Tier 3 program, Standard Plans must delegate certain care management functions and responsibilities to certified practices that meet the program's requirements. Where such delegation occurs, Standard Plans are expected to pay care management fees sufficient to support the delegated activities. While the Department has declined to establish minimum care management fees to date, the expectation underlying the AMH Tier 3 model is that Standard Plans and practices will arrive at mutually agreeable rates that are commensurate with the intensity and breadth of the care management being provided. The Department wants to ensure that the care management fees being contemplated by Standard Plans are adequate to support the level and quality of community-based care management services that DHHS expects of all care management providers, including AMH Tier 3 practices and Standard Plans. AMH Tier 3 practices are expected to comply with the requirements outlined in the Department's Advanced Medical Home Manual.

By providing additional information on the assumptions the Department used to develop components of the rate, Standard Plans and AMH Tier 3 practices will be better positioned to enter into care management contracts that enable all parties to meet the Department's expectations in the execution of care management responsibilities and achievement of improved health outcomes.

## Care Management Capitation Component

Medicaid Managed Care capitation rates paid to plans include a care management component valued at $13.41 per member per month (PMPM). This figure is exclusive of the blended average of AMH Medical Home fees ($2.58) and the continuation of historical care management payments to local health departments (LHDs) ($2.15), which were established consistent with spending levels reported by the Standard Plans within their financial reports. After an offset to account for care management overlap between Standard Plans and LHDs (-$0.43), the $13.41 includes components for the Integrated Care for Kids (InCk) pilot program ($0.31), care management oversight ($1.76), care

coordination ($1.44), and activities to address the social determinants of health ($0.15).[1]

The remainder, **$10.17 PMPM, is the assumed cost of delivering care management in accordance with the Department's requirements.** This figure is agnostic to the entity responsible for the delivery of care management and represents the expected cost to either a Standard Plan or an AMH Tier 3 practice of delivering care management. The full care management rate build-up is described in Table 1 below.

**Table 1: Care Management Capitation Component**

| Activity | Cost ($PMPM) | Description |
|---|---|---|
| **AMH/LHD Base Payments (included in the service portion of the capitation rate)** | **$ 4.73** | |
| AMH Medical Home Fees | $ 2.58 | Blended average of $2.50/$5.00 PMPM for non-Aged, Blind, and Disabled (ABD)/ABD members assigned to all AMH Tiers, based on Standard Plan financial reports. |
| Care Management for At-Risk Children (CMARC)/Care Management for High-Risk Pregnancies (CMHRP) Base Payments | $ 2.15 | Based on historical payments to LHDs as noted in Standard Plan financial reports and as outlined in the Contract ($4.56 PMPM for CMARC, $4.96 PMPM for CMHRP). |
| **Total Care Management (as provided in the Rate Book)** | **$ 13.41** | |
| **Care Management (excluding oversight/accountability, care coordination, and healthy opportunities activities)** | $ 10.17 | Intensive care management for individuals identified as being high-needs or who are transitioning out of the hospital. |
| *Low-Needs Members** | *$ 3.13* | |
| *Moderate-Needs Members** | *$ 4.07* | |
| *High-Needs Members** | *$ 2.39* | |
| *Supervisor** | *$ 0.58* | |
| LHD/Standard Plan Responsibility Overlap | $ (0.43) | Offset for care management performed by LHDs. |
| InCK | $ 0.31 | Statewide cost consideration for the InCK program ($2.04 PMPM per child enrolled within Region 4). |
| Oversight/Backstop Accountability | $ 1.76 | Standard Plan oversight and coordination with Tier 3 AMHs. |
| Care Coordination | $ 1.44 | Coordinating the provision of services across settings for all Standard Plan members. |
| Healthy Opportunities Activities | $ 0.15 | Standard Plan activities to address social determinants of health for all populations (not specific to Healthy Opportunities Pilots). |

[1] These amounts are blended across Standard Plan populations; average PMPM payments vary by category of aid, age and geography (with respect to InCK).

| | | |
|---|---|---|
| **Total Care Management and Related Activities** | **$ 18.14** | |

*PMPM cost build-ups outlined in the table below. Totals may not sum correctly due to rounding.

Table 2 below describes the buildup of the $10.17 PMPM care management component described above.**The buildup is based on a set of assumptions about care manager staffing ratios and qualifications, which should be understood as averages rather than policies about how each care team must be constructed.** In reality, care teams will vary in how they are staffed according to the needs of individual members and assigned panels. As described in Table 2, the Department assumes that 22 percent of beneficiaries will receive care management, with 11.5 percent classified as "low-needs," 8.5 percent classified as "moderate-needs" and 2 percent as "high-needs" within that 22 percent.

**Table 2: Care Management Capitation Component – Care Management Staffing Assumptions**

| Component | Share of Members | Staffing Ratio | Staff Qualifications | Average Compensation per FTE | Cost ($PMPM) |
|---|---|---|---|---|---|
| Low-Needs Care Management | 11.5% | 250 members per FTE | CHW/LPN/MA/SW | $ 81,674 | $ 3.13 |
| Moderate-Needs Care Management | 8.5% | 150 members per FTE | CHW/LPN/MA/RN | $ 86,236 | $ 4.07 |
| High-Needs Care Management | 2.0% | 75 members per FTE | RN | $ 107,504 | $ 2.39 |
| Staff Supervisor | NA | 20 per FTE care manager | | $ 107,504 | $ 0.58 |
| | | | | **Total** | **$ 10.17** |

The Department has provided this information in an attempt to ensure that the care management fees being contemplated by Standard Plans are adequate to support the level of quality of community-based care management services that DHHS expects of its AMH Tier 3 practices. **The Department has not established minimum care management fees and maintains the expectation that Standard Plans and practices will arrive at mutually agreeable rates that are commensurate with the intensity and breadth of the care management being provided.**